

Testing and Marketing the “Report Card on Washington’s Health”

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May 2003

The 1995 Public Health Improvement Implementation Act directed the Department of Health (DOH) to “identify, as part of the public health improvement plan, the key health outcomes sought for the population....”. Part of the Department of Health’s action plan to fulfill that responsibility was to issue a “health report card.”

In response to that mandate, DOH established a nineteen member “Washington State Key Health Indicators Steering Committee” representing public and private health agencies, state and local health agencies, health foundations, academia, family and community interests, and citizens. The report card designers established parameters, including the quest for a coherent vision, the extensive use of public health knowledge, a focus on health rather than disease, bringing a community perspective to the issue of health, and to select from among existing indicators.

A draft report card was issued in December of 2000. In 2002 DOH established another steering committee (see Appendix A) to review the report card and to design a strategy to encourage and enable its use to improve health in Washington State. The substantive review included interviews from key stakeholder groups as well as review from steering committee members. In addition to the substantive review, a technical review committee provided a critique with respect to measurement and data collection issues relevant to the report card.

The results of these reviews are summarized here. The first section describes the substantive review, the second describes the technical review, and the final section describes issues related to the development of a tool kit for encouraging the use of the report card to improve health in Washington State.

Substantive Review of the Report Card

1. Report card development. The draft report card developed in 2000 is shown in Figure 1. It includes 12 causal indicators and three result indicators. Health results include:

- *Years of healthy life*
- *Perceived mental health*
- *Readiness to learn*

The causal indicators are grouped within the queries:

- *How healthy are our surroundings?*
 - *How safe are our food, water, and air?*
 - *How safe and supportive are our communities?*
 - *How supportive is our health care system?*
- *How healthy are our behaviors?*

Figure 1
2000 Draft Report Card

Report Card on Washington's Health—"How healthy are we?"		
General Health Indicators		
Years of healthy life	Perceived mental health	Readiness to learn
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Specific Health Indicators		
"How safe and supportive are our surroundings?"		
"How safe are our food, water and air?"		
Illnesses commonly associated with unsafe food and water		
Air quality		
"How safe and supportive are our communities?"		
Economic		
% below poverty threshold		
Social connectedness		
Civic involvement, interpersonal trust, high school graduation rates		
Injuries and death		
Unintentional—traffic, poisoning, drowning, fires, falls		
Family violence		
Homicides and suicides		
"How supportive is our health care system?"		
Unmet need—adults, children		
Vaccine preventable diseases		
"How healthy are our behaviors?"		
"Do we use tobacco products?"		
% non-smokers		
"Do we get good nutrition?"		
5 fruits and vegetables a day		
"Are we physically active?"		
30 minutes – 5 times a week		
"Do we abuse alcohol or other drugs?"		
Binge drinking – 5 + drinks		

The causal indicators were chosen after having reviewed sources drawn from national public health, state and local public health, state and local community health, international public health, and life-course health. The sources focused on various aspects of health, including health results, health process and access to health care, prevention, and causal factors (environmental, social, behavioral). The causal factors are organized around the Center for Disease Control health determinants model with the following approximate percentages:

- *Access to health care--10%*
- *Environment (physical and social)--20%*
- *Genetics--20%*
- *Health behaviors--50%*

The audiences for the report card were defined as the public, policy-makers, local public health officials, and private-sector health care insurers and providers. Its purposes are to engage and mobilize the public and policy-makers and to learn so as to improve the health status of the people in Washington State.

2. Initial steering committee review. The 2002 steering committee was invited to comment on the report card with the goal of making modest changes that would improve the report card. The initial reactions of the steering committee are summarized as follows:

- Many of the decisions around indicators appear to have been driven by the availability of data—e.g., high school graduation, readiness to learn, nutrition—and lack of data like emergency room data. There is some value in clarifying language, such as readiness to learn (at kindergarten); and in being more precise, such as differentiating between legal and illegal drugs. There is some inconsistency in that health status is used among some determinants like illness associated with unsafe food and water rather than the frequency of its occurrence.
- For the report card to be useful to the legislature, it will be necessary to have geographical breakdown of data. Currently perhaps half of the indicators can be broken down geographically. Legislators want to know what the problem is and what they can do to solve it—more money, a bill, or a law. For example, what can they do about social connectedness?
- The report card needs to have an accompanying users guide with some suggestions about how the report card can be used to improve health—possible strategies and interventions. The report card is intended to be an educational device—to view health comprehensively. At this point there is a narrow understanding around health—the report card is an effort to broaden the perspective—to reeducate and build a data system that provides and supports that broader perspective. We have to connect the dots for people. The accompanying information will have to drill down—the report card is deceptively simple. There is a lot of embedded information in it.
- Regardless of audience, we need a discourse to demonstrate how it is meaningful to people in their lives in their communities. CD's and videos are mechanisms that

might help with this. Tools need to be developed and made available. Why? and So What? need to be readily answered with respect to the report card. Policy implications at the local and state levels need to be articulated.

- Statistics are important, but we also need to tell stories that illustrate the issues and relationships we want people to be aware of. Stories can demonstrate the causes of health. We need to assess where we can get traction. What has been done successfully? What barriers need to be overcome? For example, a Spokane company addressed smoking and weight loss among its employees. Health promotion affects the bottom line. A healthy community provides a health workforce.
- The breadth of legislative actions profoundly affect health. For example, the seat belt law has substantial health benefits, but it tended to be debated more on libertarian/civil liberty grounds. The reason for looking at it as a public health issue is that we are spending substantial funds on illness and disease. There is great benefit to focusing on health instead.
- There is often some up-front cost to a focus on health. For example, paying for gym membership might eventually reduce hospitalization at a later stage. We should be focusing on causes not symptoms.
- We can't have an action neutral score card and expect anything to change. We need to go directly to community groups/institutions and not rely on the legislature.

3. Key stakeholder review. One of the primary tasks of this review effort was to seek out reactions and comments from key stakeholders through a series of in-person and telephone interviews. The steering committee defined key target groups to include:

- *employers, especially from the private sector*
- *public education personnel*
- *active PTA members or leaders*
- *members or leaders from United Way boards*
- *members or leaders of service groups such as the Rotary, Lions, or Kiwanis clubs*
- *physicians*

Two sets of interviews were conducted. The first set included members of target groups that were primarily from western Washington and the second set were primarily with members from eastern Washington.

a. First set of interviews. The first set of personal interviews with twelve stakeholders were held in late June. Several had multiple roles, such as parent, employer and service organization leader. Using the primary role in which they were interviewed, the twelve represented the audiences as follows: one from service organizations, one from the United Way, two from schools, two from health field (but no physicians), two from DSHS, two from the business community (but only one employer), one from community networks, and one legislative staff. The twelve were sent a Wellness Fact Sheet (see Appendix B) and the draft Report Card prior to the interviews. Tables

showing data on the indicators were presented during the interview if that was appropriate to the discussion at hand.

The interviews were relatively unstructured around three broad topics:

- What is currently working well to support health in their communities, what needs improvement, and what are the barriers to improving health?
- What is their reaction to the report card—does it make intuitive sense, is it clear, are there too many items, too few? Any comments regarding the indicators?
- How might the report card be used to improve health? What would it take for the report card to be useful and actually be used? What kinds of materials and tools need to be developed?

The interviewees varied considerably with respect to their health related backgrounds and their roles. Some talked in detail about the specific indicators, some spoke more generally about health and their communities, and some focused on specific populations. Two common refrains did emerge from the varied discussions.

- One refrain is the need for and importance of repetition with respect to the education message. People need to hear things over and over again from multiple sources/media in order to “get it.” One person noted that it will take a 10 to 15 year campaign.
- Another refrain is the need for clear accountability built into the report card if it is to be more than another piece of paper with data. Financial rewards and penalties are essential, such as tying local hospital administrator salaries to community health outcomes.

Other comments addressed the structure and design of the report card, the indicators, materials and medium of messages, and what can be done.

Structure and design of the report card. People were interested in the CDC determinants of health and felt that it told a powerful story. Most were surprised at the relatively low contribution of the health care system to health. Most thought that the report card design should clearly portray the relative determinants of health, whether with a pie chart (visually) or with numbers (50%, 20%, 10%). Understanding the determinants and the proportions opens up thinking about health.

Most thought the number and types of indicators on the report card were about right, but one person thought there was too much detail on the “Supportive” side of the card. He thought there should be more balance between the left and the right, especially since behavior is the larger determinant of health. One person commented that we read from left to right and therefore behaviors, which are the larger determinants should be on the left rather than the right.

Some commented that the report card needs to be designed as a marketing message and designed to highlight the key ideas. It needs better graphics, use of color and fonts.

Indicators. A couple of people wanted the health status indicators to be parallel. Years of health life is followed by “perceived” mental health. Why perceived? And “readiness to learn” is a non sequiter. “Early brain development” would be better.

The standards suggested by the indicators for nutrition and exercise are too high. The measures should gauge whether we are making progress toward better nutrition and sufficient exercise. Nutrition should reference breakfast eating.

“Unmet need” was not readily understood and needed explanation. Everyone thinks in terms of access—do you have it or don’t you? Emergency room utilization would be a good health care system indicator.

Almost everyone who focused specifically on the indicators commented on “binge drinking” as an inadequate measure of drug and alcohol abuse. A couple of people talked about methamphetamine and labs given that it is a hot issue.

OSPI’s measure of high school graduation rates is not very good. Encourage OSPI to get a better measure. (They are developing a student id number that would support a better measure).

It is important to measure the general degradation of water and the food chain from reproductive hormones in the water, antibiotics in meat and pesticides in food. Are we currently testing for those things?

Materials and medium for message. As noted, almost everyone thought the determinants of health, including their relative strengths, should be highlighted in the report card and supporting materials. It was seen as the key message that was empowering and also suggested responsibility and accountability for one’s health. “Citizens are responsible for their health!”

However, it was also thought that the message was important as a part of a larger drumbeat—that the message had to be heard from many sources, not just the health department, and that standing alone, the report card probably won’t accomplish much.

People thought that it was important to show the relationships between and among variables, such as between health and success in school and school impact on health. Benchmarks should be developed around those interconnections. For example, explain that communities that support kids have high graduation rates and benchmark communities around that. This communicates that it is not just the responsibilities of the schools and parents, but that the broader community has some responsibility.

There is an opportunity with the tobacco settlement money to impact health through education around health issues. Cable TV is an important resource. Audiences can be specifically targeted relatively cheaply (men, women, older people, teens etc.).

Libraries are an important resource in disseminating this kind of information

The community information line, 211, is not completely designed as yet, and that might be a communications resource for health information/education.

Materials should tell stories that are real. Publicize success stories, especially local (Washington State) success stories. Specific steps that people can take need to be outlined. Steps and strategies should be articulated for individuals, businesses, neighborhood associations, and county/city collaboratives.

Data should be disaggregated geographically. All politics are local, and successful interventions will only occur locally. Data should also be disaggregated for low income people. There is a huge difference between them and the more affluent folks where health is concerned

You need a “Who” to go with the “What” of the message. The who is preferably someone outside of the health field. Various names were mentioned by different interviewees including the Governor, Bill Gates, Chairman of the Board for Boeing, and the U.S. President.

When communicating with physicians you have to tap into specialties—make it relevant to the specialty. E-mail is a good way to communicate, as well as specialty newsletters.

The Association of Washington Businesses publishes a monthly newsletter and a quarterly magazine that could be used to communicate success stories about wellness programs. It would be helpful to have better measurements/estimates of the benefits of wellness programs. Business is very clear about the cost aspects; it is less clear about the financial benefits. Credible, understandable estimates or methods for determining them would help businesses focus on benefits rather than just costs.

Policy makers often see their decisions as funding health (e.g., parks) or economic development. We have to show that health IS economic development (healthy community=healthy workforce=effective economic development).

What can be done? Several interventions were mentioned. For example, teaching young children proper hand washing led to fewer illnesses and missed school (daycare).

Schools can improve lunches nutritionally, put juice instead of soda in vending machines, support physical activities, and provide health education. However, others noted that schools needed to focus on reading, math and science. Also, there needed to be a balance between nutrition and what kids will eat. The money from vending machines is used for key educational activities, and vending machines will lose money if soda is not provided.

OSPI has continually delayed implementation of the healthy fitness assessment tool in its accountability system. It is now slated for 2010, and some think that it is unlikely to be implemented at that point. It has also now been combined with the arts and social studies assessment, further watering it down.

Various employee wellness plans were mentioned including Glaxco-Smith-Kline (which went through a merger and might not be doing it anymore), Hewlett Packard which is merging with Compaq. Boeing has a gym, but doesn't promote its usage. Snohomish County Government had a health incentive program earlier (HOP for health), but dropped it due to budget cuts.

Develop and implement a FAT tax similar to taxes on tobacco and alcohol, such as a penny per gram of fat. This could fund a lot of health education and health care programs, not to mention parks and safe places to walk.

A food pyramid on the refrigerator is a helpful reminder at the individual/family level.

b. Second round of interviews. The power of the CDC determinants with the first round of interviews raised the question of the source for that material. While it is attributed to CDC and is cited to CDC, the underlying methods or research for those determinant proportions had not been examined. Other authors have a slightly different distribution regarding determinants. If the visibility of the determinants is increased in order to highlight the power of that framework, it must be ensured that it is well-researched, credible, and sourced. McGinnis states proportions at 30% genetic, 20% environment, 40% behavior, and 10% shortfalls in medical care (J. Michael McGinnis, Pamela Williams-Russo, and James R Knickman, "The Case for More Active Policy Attention to Health Promotion. Health Affairs, p 4, March/April 2002). Another CDC source (USDHEW, PHS, CDC. Ten Leading Causes of Death in US 1975. Atlanta, GA, Bureau of State Services, Health Analysis & Planning for Preventive Services, p 35, 1978) indicates the proportions 17% genetic makeup, 22% environment, 53% behavior, and 10% medical care. The steering committee felt that it would be appropriate to present ranges rather than specific proportions:

Relative determinants of health—

- ***10% health care delivery***
- ***20 – 30% genetics***
- ***20% environment***
- ***40 – 50% behavior***

The interventions suggested in the first round of interviews in response to how the report card might be used to improve health focused primarily on schools and children. However, the interventions (steps, strategies) suggested in a tool kit ought be drawn from among those with proven effectiveness. The Health of Washington State includes effective interventions for each health topic, and that is an appropriate place to start.

It was determined that the second round of interviews would focus particularly on stakeholders in Eastern Washington, and would include more employers. Interventions regarding improving health would be downplayed because interventions with proven effectiveness are the goal. In addition, the steering committee decided to specifically test the “readiness to learn,” label, with “healthy child development” and “early child development” provided as possible substitutes.

Seven interviews were conducted with two from the business community, two from education, one from a religious community, one from a local community group, and one from the health system. Five of the stakeholders were from the Spokane area, one from the Vancouver area, and one from the Olympia area.

The feedback was similar to that heard in the first round of interviewing. In general, the layout and organization of the report card made sense to stakeholders. Few were surprised by the significant role played by behaviors and the environment, but some thought that certain audiences, such as employers, might be quite surprised at the relatively small weight attributed to the health care system. One person expressed concern that the small weight accorded to the health care system might suggest to policy makers that they need not fund health services.

As heard previously, additional indicators were suggested, including child care, housing, and drug use (especially methamphetamine production/use). The relationship of some indicators (e.g., poverty) to health care was not readily understood by all. Bio-terrorism did not surface in the discussions as a key indicator or determinant of health.

With respect to “readiness to learn,” stakeholders liked the notion of an early childhood development label, but there was no agreement regarding which of the three labels was preferable. The measure “successfully completes kindergarten” was also raised with stakeholders. Stakeholders were not entirely satisfied with successfully completing kindergarten as a measure.

Stakeholders noted that information about intervention strategies is needed to make the report card useful. The materials should be designed by marketers. Community groups and leaders can help disseminate materials. Stakeholders urged that materials be kept simple. Details should be available for those who want to look them up, but should be kept separate from the report card.

4. Modifications to the Report Card. The steering committee made a number of modifications to the report card on the bases of stakeholder reaction, their own review and the technical review (discussed below). Committee members determined that the childhood development label would be **Healthy Child Development** rather than “Readiness to Learn.” Measures with existing data for healthy child development are inadequate. Therefore DOH will work with OSPI over time to develop a better measure.

Another result indicator, “Perceived Mental Health” was changed to ***Emotional Well-Being***.

Changes to the food, air and water section included:

- “Illnesses commonly associated with unsafe food, unsafe water ***or poor hygiene***”
- “Safe drinking water ***system***”

Changes to the safe and supportive community section are:

- Combined “***Civic involvement/interpersonal trust***”
- “***School retention rates***” instead of high school graduation rates
- “***Unintentional injuries***” without specification of five top
- Family violence was divided into “***Domestic violence***” and “***Child abuse and neglect***”
- “***Violent Crimes***” replaced Homicides and Suicides

Behavioral items were changed to:

- “***Do we smoke cigarettes?***”
- “***Do we eat fruits and vegetables?***”
- “***Do we abuse alcohol?***”

The final report card is shown in Figure 2.

Figure 2
2003 Report Card



Technical Review of the Report Card—Measures and Data

A technical review committee met after the draft report card was developed to discuss the measures that had been proposed as well as indicators for which no measures had been identified. Data availability were also reviewed. Criteria used for the technical review of indicators were:

- *Valid*
- *Reliable*
- *Responsive*
- *Understandable*
- *Available*
- *Abuse-proof*

As a general matter the technical review committee recommended using rates per 100,000 instead of numbers. Rates provide consistency and also provide independence from population growth. Issues raised by the technical committee, steering committee discussion, and decisions are summarized below:

- **“Years of Healthy Life”**
- Healthy Life Expectancy (CDC)
 - Mortality data
 - BRFSS—“Would you say your health in general is excellent, very good, good, fair, or poor?”
- Label as above rather than “Health Expectancy”
- ***Decision: Accept technical report modification re the measure. Retain “Years of healthy life” label. Don’t separate out males and females in displaying data***
- **“Perceived Mental Health”**
- BRFSS: “Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?”
- Reporting more than 14 days (CDC—frequent mental distress)

Discussion: Stakeholders did not like “perceived” in the label. The steering committee discussed the concept, and it had more to do with emotional well-being than mental illness, which is what comes to mind with the label “mental health.” The proposed modification is more a measure of clinical mental illness—frequent mental distress—rather than getting at emotional well-being.

Decision: *Label the health status “Emotional well-being.” Measure it with a new BRFSS item that combines the above item with the item that measures loss of functionality due to physical and mental distress, modifying the item to delete physical causes. “Now thinking about your mental health which includes stress, depression, and problems with emotions, for how many days during the past 30 days were you unable to care for yourself or participate in recreation.....” The measure will be the proportion of population that experiences X number of days. The X might be zero, but the data will be examined to see what the best cut-off is. That question will be asked in the 2002 survey.*

■ **“Readiness to learn”**

- Proportion of children in the 3rd grade who exceed the national average on the reading and mathematics composite score.

Discussion. For some stakeholders, readiness to learn was a non-sequiter. The indicator was to capture a summary of pre-natal care, nutrition, brain development, social development, and immunizations. Two other labels—“Early child development” and “Healthy child development” were considered. The proposed indicator of 3rd grade mathematics rating was not acceptable because it comes too late (3rd grade), and standardized tests are problematic. Proportion of children who repeat kindergarten was discussed as a better measure. That would be feasible when schools implement an individual tracking system. It would also provide information to look at age entering kindergarten. “Healthy child development” was criticized because it implies that a child that repeats kindergarten is unhealthy.

Ultimate decision. *Label the indicator “Healthy Child Development.” Work with OSPI to develop a good measure.*

Surroundings—food, air, water

- **“Illnesses commonly associated with unsafe food and water”**
- Add “and poor hygiene”
- Rate per 100,000
- Exclude hepatitis A (it is included in vaccine-preventable diseases)

Decision. *Accept proposed modifications*

- **“Safe drinking water” —% of the population for whom drinking water systems are out of compliance**
- % of the population on public water supplies that are in compliance with monitoring and all water quality standards

Decision. *Accept proposed modifications*

Surroundings--Communities

- **“Civic Involvement” –**“Now we would like to know something about the groups or organizations to which individuals belong. Here is a list of various organizations. Could you tell me whether or not you are a member of each type?”
- Social Capital Index – domains
 - In the past year, did you serve on a committee for a local organization? Yes, no, DK, refused
 - In the past year, did you attend a public meeting on town or school affairs? Y, N DK, R
 - How many times, if any, did you do volunteer work in the past year? None, 1-4, 5-8, 9-11, 12-24, 25-51, 52+ DK, R
 - How many times, if any did you entertain people in your home in the past year?

Decision. Accept proposed modification. Incorporate the item for interpersonal trust in the social capital index and have a single measure rather than two measures. Labeling the combined measure was not discussed.

- **“Interpersonal trust” –**“In general do you think that most people try to be fair? Or try to be helpful? Or can be trusted?”
- **Generally speaking, would you say that most people can be trusted or that you can’t be too careful in dealing with people? Most people can be trusted, Can’t be too careful, Depends (if volunteered), DK, R**

Decision. See Civic Involvement above.

- **“High School Graduation”**
- % of students enrolled in 12th Grade in October who graduate

Discussion. Stakeholders did not like the OSPI definition nor did some committee members. People want to know about those who drop out at 9th, 10th, and 11th grade. A measure of school retention grades 9 through 12 is probably better. Status unknown would be counted as non retained. Schools currently report things variously with respect to status unknowns. OSPI has not encouraged consistency in reporting, which means drop-out rates are easily criticized. We figure that if they don’t like the way status unknown is treated, they can develop and implement a more reliable and valid measure.

Decision. The indicator will be “% of students grade 9 through 12 enrolled in October who are still enrolled at the end of the school year.” The label will be “School retention rates”

- **“Injuries and death” --# of injuries and deaths from traffic-related, poisoning, drowning, fires and falls—inpatient hospitalizations in non-federal facilities**
- **“Injuries and violence”**
- **Rate of injury-related deaths per 100,000 population from 5 causes—breakdowns for 0-14 and 15-24 ages**
- **Hospitalizations for falls in adults over age 64**

Discussion. Perhaps some of the enumerated items could be eliminated in the area of injury and death. There are many things excluded elsewhere in the report card in order to keep it simple and short. Rather than enumerate the most frequent causes of unintentional injuries, all unintentional injuries could be included, thus removing some of the clutter. Anything worth highlighting could be noted in accompanying text.

Decision. Label the area “Injuries and violence.” Include all unintentional injuries. “Rate of injury-related deaths per 100,000 population.” Do not break down the data for 0-14 and 15-26.

- **“Crimes involving domestic relationships” – “# of reported crimes involving domestic relationships”**
- # of offenses involving domestic violence per 100,000 population as reported from local police jurisdictions to WASPC (felonies, gross and simple misdemeanors, and violations of protection and no contact orders)

Discussion. Family violence is so important at the community level, even though it would be nice to eliminate something in this section. Stakeholders were very happy to see it in the report card.

Decision. Accept proposed modifications.

- **“Child abuse and neglect” – “# of suspected cases accepted for investigation by CPS”**
- Duplicated count of children in accepted referrals per 100,000 children

Decision. Accept proposed modification.

- **“Homicides” – “# of deaths per 1,000 population due to homicide”**
- Homicides per 100,000 population
- Ditto for Suicides

Discussion. Are homicides that important to include, given all the things we left out of the report card? It is such a small proportion of violent crime. Suicide could be covered in a discussion of emotional well-being. Could these be eliminated? But crime is an important issue at the community level, especially violent crime. The FBI Crime Index includes major, mostly violent, crime. Indexed crimes include murder, forcible rape, robbery, aggravated assault, burglary, larceny-theft, and motor vehicle theft. A measure of arrests for Index crimes (or violent Index crimes) could cover it.

Decision. Remove homicides and suicides and replace with a measure of arrests for Index crimes.

Surroundings—Health Care System

- **“Vaccine-preventable diseases”—“# of cases of pertussis, haemophilus influenza,**

measles, mumps rubella, tetanus, hepatitis A and B”

- Per 100,000 population

Decision. Accept proposed modification

Behaviors

- **“Abuse alcohol and other drugs”**
- **“Binge drinking” or “heavy drinking” label**

Discussion. Stakeholders raised the issue of drugs. Several mentioned methamphetamine. Drugs contribute to collateral community damage. But many things are left off the report card. Drinking is the bigger health related problem. Drug related deaths can be noted and highlighted as appropriate. Stakeholders saw the label of “Binge drinking” as too narrow.

Decision. Label the behavior alcohol abuse. Remove the label “Binge drinking” and leave “5+ drinks on one occasion”

Baseline data were presented for most of the indicators, along with charts, titles and brief text to describe the indicator and data. By and large, the charts representing the data worked well. The steering committee suggested the following regarding data presentations:

- ***Make the titles to the charts more conversational—a sound bite about the data.***
- ***Keep the charts simple—e.g., combine men and women for years of healthy life.***
- ***Where there is likely to be variation (e.g., implications of double the poverty level will vary by region), note that in the text. Note “double” poverty rate in the title.***
- ***Make zero the bottom of the y-axis for all charts***
- ***Represent the healthy perspective in the charts--% that don’t smoke rather than % that do smoke***
- ***Check to see if teenager perpetrators are included in domestic-violence related offenses***
- ***Include a placeholder for indicators for which we have no data.***
- ***Keep the text non-technical; put technical discussion elsewhere***

BRFSS is the data source for many of the indicators. Typically, the sample size is too small to disaggregate geographically, except perhaps urban/rural desegregation. It will be necessary to have county level data for the report card to be useful and used across the state. Tobacco money will be used to increase the sample size of the 2003 BRFSS to provide a minimum of 200 interviews per county. Counties can add additional interviews at a marginal cost. An additional 400 interviews (bringing the county total to 600 interviews) would cost approximately \$12,000 - \$14,000 for a county. An additional 200 interviews would cost about half that amount. Only CDC core questions are covered in this estimate, but that does include the behavior questions, which are the biggest health determinants. Additional county level interviews would provide excellent baseline data

with respect the report card. This information was posted to counties and disseminated through assessment coordinators so that counties could take advantage of the county level sampling frames for the 2003 BRFSS.

A Tool Set

The stakeholders interviewed emphasized the need for simple, clear material to accompany the report card. They identified the need for clear strategies and interventions that could be pursued to improve health. Some mentioned the need to explain more fully the relationships between the causal factors and health results. Others mentioned the need to explain why these indicators were chosen over others—the reason being that the chosen indicators are meta-determinants, based on science.

The steering committee envisioned a toolset that would be disseminated to communities with the report card and would provide the following types of information:

- Current levels for each measure (in Washington and in other states, if that information is available)
- Information on the impact of changes in the measures in terms of benefits to the community (i.e, an increase in school retention rates can be expected to result in a decrease in unplanned pregnancies, or whatever)
- Strategies, steps and costs to make changes in particular measures, including examples and reference to any studies containing science-based interventions.
- Criteria for setting targets (issues for communities to consider if they want to set their own targets for the measures).

The steering committee struggled with two tensions that surfaced repeatedly. The first tension involved the desire to keep the tool set simple and accessible, while at the same time provide the explanations, illustrations, references, and research to back up the report card and interventions. The assumed resolution to this tension was to provide layers of information with the first layer quite simple, but that provided the user with references to more detailed information, which provided further sources etc. A layered approach is undoubtedly necessary, but a layered solution requires a substantial design effort as well as significant and on-going maintenance. It is difficult to keep the first layer simple if it must provide ready reference to proven illustrations, the science involved, and explanations.

The second tension involves the desire to include only proven interventions and strategies (or highly promising interventions, with the interventions so noted) within a report card framework that is ahead of practice. While science supports a framework that includes community as a key environmental factor related to health and that emphasizes healthy behaviors, most health investments have been made in health care system interventions, rather than in community support of health or community involvement in modifying behaviors. The health report card is, in fact, an effort to modify the investment strategy. This is a catch 22 situation without an obvious solution in the short term.

1. *Strategies and interventions.* The steering committee wanted strategies and interventions appropriate for each of the twelve indicators with proven pay-offs. Traditionally, the level of investment in interventions with proven pay-offs has not been great. It was recognized that cost/benefit information is seldom available and even evidence regarding effectiveness will be often be lacking. In that case sound theory must be present. environmental indicators. questions, and in fact, we might not always have evidence about proven effectiveness. But the interventions included either must have proven effectiveness or at the very least, be based in sound theory.

The committee wanted interventions identified for different. At one point, the committee explored organizing interventions in a matrix with indicators on one axis and actor on another. Actors were identified as:

- Community
- Employer
- School
- Individual/family
- Health care providers
- Public health

It quickly became evident “actor” was not the appropriate dimension. In some instances an intervention is appropriate in a location, like workplace or school, but the actor is the individual. The matrix notion was abandoned and the idea of highlighting certain interventions appropriate to various actors was substituted.

The primary sources for identifying proven and promising interventions to improve health were “The Health of Washington State” published by the DOH and “The Community Guide” published by CDC. The Community Guide is a set of recommendations regarding population-based interventions for a variety of public health topics including tobacco product use, alcohol abuse, physical activity, vaccine preventable diseases, mental health, motor vehicle occupant injury, violent and abusive behavior, and the sociocultural environment. Other areas will be addressed in the future, including promotion of healthful diets. The recommendations are based on proven effectiveness. Recommendations for other areas are due in 2003 and beyond.

There was a strong interest in identifying Washington State examples of effective interventions for each of the indicators. Stakeholders mentioned that the closer to home the example, the more likely that people would take action. A substantial effort was made to identify and describe effective Washington State interventions for each of the indicators.

2. *Setting targets.* Targeting is designed to answer the “So what?” question—what should our health be? However, setting targets is tricky. Who is the audience for the targets? What is the accountability around the targets? What is the intervention/strategies that lead us to think things will change?

The initial plan had been to set state-wide targets for each of the indicators. However, because interventions and the effort around them will be chosen by individuals, communities and others it did not make sense to set targets. Intelligent target setting is guided by baseline data (which also varies among communities), the type of intervention and the effort expended, and the duration of the intervention. People and communities can learn where they are with respect to trends and with respect to national measures, other states, Washington state and other communities in Washington State (to the extent that data are available).

Targets are therefore best set in conjunction with specific interventions. It was determined that the tool set would include a brief explanation of targeting and evaluation (see Appendix C). This piece is to do the following: outline the value and process of setting local targets (simply and non-technically); show that evaluation is one component of intervention; and outline different standards depending on whether the intervention has been proven effective (a lower standard—baseline data and outcome data) or whether it is a promising intervention (a higher standard—baseline data, outcome data and process data). It is important to help people understand that perfect information and research is not required for analysis to be beneficial.

3. *Ambassadors for the report card and tool set.* The report card and tool set will need ambassadors to facilitate their use. Assessment coordinators can help play this role as can partners in PHIP. A training program is needed for ambassadors to show how the tool kit can be used/useful so that they are well-schooled and can infect the community. Local boards of health might be enlisted. Training sessions for legislators and staff would be useful. The messages are “How do we make smart decisions?” “Don’t settle for less than smart decisions and good investments.”

Appendix A
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Appendix B

Wellness as an Approach to Health in Washington State

Costs of Health Care. The costs of health care are increasing significantly. Nationally, medical care expenditures increased by 8.6% during 2000-2001, *a rate 2.5 times the rate of general inflation*. Increases are driven by several factors, including a population that is growing older.

The costs of health care are currently borne by a mix of private and public sources. Taxes fund Medicare, Medicaid, health insurance for public employees and other government programs. In 2000, 41% of Washington residents were insured through these government programs. Growing enrollment in these programs and rising costs are expected to cause *an increase in the Washington State expenditures from \$4.7 billion in 1999-2001 to \$5.4 billion in 2001-2003, an increase of 15%*. Private employers are also a key funder of health care. In 2000 private employers insured 46% of Washington residents. *Premiums for employer-funded insurance rose 8% in 2000 and 11% in 2001*. Only 5% of Washington residents purchase health insurance through the individual market. About 8 to 9% of Washington residents have no health insurance.

Determinants of Health. The health care system plays an important role in ensuring the health of the people in Washington State. But the increasing public and private resources needed to run that system are fast outpacing the ability to provide them. This situation is causing a reorientation and refocusing of attention on wellness and health, rather than illness and disease.

The determinants of health, as reported by the Center for Disease Control (CDC) indicate that *only 10% of health is determined by access to health care*. The largest determinant of health is individual behavior, such as good nutrition, exercise, and avoiding tobacco use and substance abuse. *Fifty per cent of health is determined by behavior controlled by the individual*. The physical and community environment is also important to health. *Twenty per cent of health is determined by environmental factors like clean water and air, safe streets and homes, and supportive communities*. An additional 20% of health is determined by genetics.

PHIP Report Card on Washington's Health. An understanding of the determinants of health led health and community leaders to draft a report card for Washington State under the auspices of the Public Health Improvement Program. The report card focuses on the key causes of health—individual behaviors (nutrition, exercise, avoiding tobacco and substance abuse) and our surroundings including the physical environment (clean air and water, safe food), the community (economic, social connectedness, safety), and access to health care. The report card is also designed to assess the resulting health of Washington State's population by looking at the expected years of healthy life in Washington State, the mental health of Washingtonians, and children's readiness to learn.

Using the Report Card. Now that the report card has been drafted, it is time to explore potential uses of report card information with citizens, employers, community groups and institutions, and government officials and staff. Does the report card focus on issues that are important to Washingtonians? How might the information be used at the community and local levels? What kind of tools might enhance the report card's utility? What media are best for various audiences? The goal is to not just have useful information, but to have information that is actually used to improve the health of Washington State.

Appendix C

Targeting and Evaluation